Terminal Illness Care Directive Form

Please complete the following information regarding your preferences for medical care during a terminal illness.

Patient Information

Full Name

Date of Birth

Address

Directive Preferences

Please specify your wishes for care and interventions:

Pain Management Preferences

Life Support Measures

Artificial Nutrition & Hydration

Health Care Agent (if any)

Agent Name

Agent Contact Information

Other Notes or Instructions

Patient Signature

Date

Witness Signature

Date